


**ILLINOIS DEPARTMENT OF  
HEALTHCARE AND FAMILY SERVICES**
**NON-EMERGENCY TRANSPORTATION  
FINGERPRINT FORM**

PLEASE PRINT ALL INFORMATION

Provider (Company) Name: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.\_\_\_\_\_  
(Maiden Name /Formerly Used Name) Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address

City State Zip Code

Position Held: (Check one)

☐ Stockholder/Owner☐ Partner in Partnership☐ Sole Proprietor☐ Officer☐ Manager (dispatcher or individual in charge of day to day operations)

I HEREBY AUTHORIZE the performance of criminal background checks in accordance with 305 ILCS 5/12-4.25 (G-5)(2) to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I understand that present and/or future information and assistance from the U.S. Justice Department and the Illinois Law Enforcement will be utilized to conduct this investigation. The criminal history investigation may be used for considering an application as a provider of non-emergency transportation services or other enforcement of Medicaid, Medicare and Department of Public Aid rules and regulations.

I understand that information obtained as a result of my authorizing this investigation is confidential and may be shared with my employer, prospective employer or with IDPA administrative personnel for enforcement of rules and regulations. Under penalty of perjury, I hereby declare and certify that the information I have provided herein is true, correct, and complete. I acknowledge that any falsification or omission may result in disapproval, suspension, or termination of a provider's approval application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE LIVE SCAN TECHNICIAN**

Proof of Identification: (Must be current)

☐ Drivers License☐ State Photo ID☐ Military ID☐ FOID

Technician Name: \_\_\_\_\_ Date: \_\_\_\_\_

ORI: IL920600Z

Completion of this form or compliance with instructions is voluntary; however failure to do so may affect this Department's action. Form approved by the Forms Management Center.

## FINGERPRINT-BASED BACKGROUND CHECK REQUIREMENTS

### WHO MUST SUBMIT FINGERPRINTS?

The following individuals associated with the Non-Emergency Transportation Company are subject to the fingerprint-based background check:

1. For a corporation, every shareholder who owns, directly or indirectly, 5% or more of the outstanding shares of the corporation.
2. For a partnership, every partner.
3. For a sole proprietorship, the sole proprietor.
4. Each officer and each manager of the transportation company. Managers shall include dispatchers and all individuals in charge of day-to-day operations.

An application to become a transportation provider or a provider re-enrolling will not be approved until all applicable individuals have submitted this form along with their fingerprints for electronic processing and such processing has been completed.

### WHAT IS THE TIMEFRAME FOR SUBMITTING FINGERPRINTS?

For new provider applicants, all individuals identified above must submit their fingerprints within thirty (30) days of the submission of a provider application. For re-enrolling providers, all individuals must submit their fingerprints within sixty (60) days after the submission of updated enrollment information.

### WHERE SHOULD FINGERPRINTS/FORMS BE SUBMITTED?

All individuals identified above must complete this form and deliver it to one of the approved vendors for electronic fingerprint processing by the Illinois State Police and the Federal Bureau of Investigation. A listing of approved vendors is provided with the enrollment packet. This list may be obtained from:

Provider Participation Unit  
IL Dept. of Healthcare and Family Services  
P. O. Box 19114  
Springfield, IL 62794-9114  
Telephone: 217-782-0538

### WHAT IS THE COST FOR SUBMITTING FINGERPRINTS?

Information regarding fees may be obtained from the respective vendor. These fees are the responsibility of the individual being fingerprinted or the transportation company.

## INSTRUCTIONS FOR COMPLETING THIS FORM

Please print all information. All fields on this form must be completed. All identifying information must be accurate and complete.

**Provider (Company) Name**      Name of the transportation company

**Name**      Current and all former names including alias used by the individual must be included. If Maiden Name/Formerly Used Name is not applicable, write "none" on the line.

**Sex**      "M" for male or "F" for female

**Race**  
B      Black or African American  
W      Caucasian  
A      Asian/Pacific Islands  
I      American Indian  
U      Unknown/All Others

**Hair Color**  
BRO      Brown  
BON      Blond  
BLK      Black  
RED      Red  
GRY      Grey  
BLA      Bald

**Eye Color**  
BLU      Blue  
GRN      Green  
BRO      Brown  
HAZ      Hazel  
BLK      Black  
MUL      Multi-colored

**The person submitting their fingerprints must sign and date this authorization form at the time of fingerprinting witnessed by the fingerprint agent.**